SOUTHWESTERN VERMONT COUNCIL ON AGING

COMMENTS/QUESTIONS
ON THE 8/4/03 Draft
1115 Demonstration WAIVER PROPOSAL

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- Will the 1115 Waiver replace all current HCBS Waivers?

It will replace the current HCBS Elderly and Disabled Waiver and the Enhanced Residential Care Waiver, but not the TBI Waiver.

- Will people need to be re-enrolled in 1115?

It is the Department's proposal that people participating in the Home- and Community-Based Waiver and residing in nursing facilities at the time the demonstration begins will be grandfathered into the long-term care program.

- Will all waiver clients need to be re-assessed when this 1115 Waiver starts?

No.

- Will Home Health agencies have enough staffing to service all the 1115 Wavier people if additional people are added? (Currently under the HCBS Home Health agencies are not able to cover all the needs.

The Home Health Agencies have stated publicly and in their written comments on the waiver proposal that they fully expect to be able to meet demand as a result of the proposal.

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- It's laudable to encourage use of private Long-term care insurance. Access for our client population will be difficult if not impossible given the cost of such coverage. Will the incentives be significant enough to encourage participation by people on limited incomes?

Since we have not yet begun development of the initiative regarding Long Term Care Insurance it is too early to say what incentives there might be. **We would like to also point out that any public education campaign focused on Long-Term Care Insurance would be targeted to the general population, not just the population served by the Area Agencies on Aging.**

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- There is a strong feeling in Bennington County that the number of readily available nursing home beds works against the people choosing a home based option. Will the number of beds be reduced?

The demonstration will not, of itself, reduce the number of nursing home beds; however, if this new long-term care program provides equal opportunity to access home and community-based services or nursing facility care, our hypothesis is that more individuals will choose home and community-based care. DA&D local staff will address all options with consumers and no one service will be favored

- The 1115 waiver hypothesizes that "given equal access… more individuals will choose home-based care". This may not prove to be true, especially in situations where caregivers have to deal with the "Big 3 Difficult Behaviors": agitation, wandering, and incontinence of bowel/bladder.

Many consumers and families will continue to utilize nursing home care for the reasons stated. That situation occurs today. Overtime we hope to be able to offer more support for caregivers, which will help support their efforts to provide care in home-based settings.

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- How will any savings realized be protected to actually fund the needs of the "expansion groups".

Changes in the State's fiscal situation always have the potential of affecting program funding; however, the legislature understands the imperative of controlling ever-increasing costs of long-term care. Since we will be working with a global long-term care budget, we can determine how to reallocate any funds that are not needed to serve the Highest Need group. As described in the proposal, these funds would be targeted first to the High Need and then to the Moderate Need groups.

- Will the 1115 waiver be paying for the "monthly required CM visit for the "moderate needs" subgroup?

Yes, for those people who were not already receiving case management services; however, we must still determine how to ensure that 1115 Waiver case management doesn't supplant case management paid for by other funds such as the Older Americans Act. We are reconsidering whether we will require monthly face-to-face visits for the Moderate Need group.

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- It may be wise to consider a higher resource limit ($10,000) for both persons receiving home-based as well as nursing home care. What if a client gets better in the NH and is able to go home… the $2,000 resource limit makes it virtually

impossible for an individual to do this. The resource limit difference, though understandable, may also raise the question of "fair and equal" access.

We are researching various ideas to protect an individual's assets during a short stays in a nursing home.

The Department feels the different resource limits are appropriate because people living at home have costs related to maintaining their homes that people in nursing homes do not.

- It states that that certified case managers will assist the individual through the Medicaid application process as needed. What about others, e.g., private Case Managers or PATH workers?

The Department envisions that little will change in this process under the demonstration, except for the addition of presumptive eligibility for the financial criteria.

- Re: "Enrollees who 'knowingly mislead or misinform DA&D…" How will this be determined? What is the standard of proof will be required? Will this be a Medicaid fraud Unit or DA&D employee task?

As a result of several comments received, we changed the language in the proposal so the word "knowingly" no longer appears. We recognized that it would be difficult to prove that someone "knowingly" misled or misinformed DA&D.

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- "The individual is assisted in making the choice of NH or Community based care" Who will assist the individual to make their decision? DA&D only? A case manager from AAA or HH? Or all of the above? Will the DA&D staff person "secure the placement for the client?"

The Department envisions that the process will remain much as it is today after the initial assessment. We have removed the language that referred to the DA&D staff securing placement for the client.

- What are a client's rights of appeal of the DA&D employee's assessment if they disagree with the determination? What is the 1115 Waiver Appeal protocol in general?

Appeal processes will remain as they are today.

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- What will the "Initial Care Plan "look like that the DA&D personnel makes out with the client? How much information will be in this initial assessment? It seems that a Comprehensive Assessment needs to be done before a Care Plan can be developed.

The initial assessment and care plan will be for the purpose of eligibility determination, to assist the individual in making an initial choice of care setting and to initiate services. A comprehensive assessment and care plan will then be completed by a certified case manager as is done today. The DA&D employee will work closely with the local agencies to secure any known information about the individual.

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- It appears that High and Moderate Need groups may only get partial services… due to lack of funds. Will these clients be considered enrollees? If so, does this mean that there are in effect some "Full slots" and some "Partial slots"? Will this generate a lot more paperwork?

"Slots" will no longer exist in this new long-term care program. These individuals will be enrollees. The High Needs group will have access to the same menu of services as the Highest Need group, based on an individual's assessed needs. The Moderate Needs group will also receive services, based on their needs. Services for the High Need and Moderate Need groups will depend on the availability of funds.

- "All Enrollees will be eligible for case management services"… What is the definition of an enrollee? Will the 1115 Waiver pay for all case management services provided to enrollees, even those in the enhancement group?

Any individual who meets the criteria for one of the three groups will be an enrollee. The Demonstration will cover the costs of case management for all groups, except people in the Moderate Needs group who are already receiving case management at the time of enrollment. We are aware that 1115 Waiver funds cannot and should not be used to supplant services paid for by other funding sources, such as case management services provided by funding from the Older Americans Act.

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- What is a "Back-UP Care Plan" in case of an emergency?

A back up plan is the part of the care plan that outlines a contingency plan for special situations such as what to do if caregivers are unavailable for a period of time for a very disabled person.

- "The certified case manager will meet face-to-face with each enrollee at least monthly." Current HCBS standard is a face-to-face meeting every other month. The monthly standard is not a realistic expectation given present staffing and caseload sizes for AAA case managers.

The Department believes it is reasonable and important to have face-to-face contacts at least monthly. The costs for these visits are covered under the current Waiver and will be under the demonstration.

- If this is requirement is maintained the 48 hour/yr limit on billable hours needs to be increased.

The Department is not clear why this is the case since the average number of hours billed for a participant in the HCBS Waiver now is 16.5 hours.

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- "Enrollee who might not otherwise appear eligible for NH care, but, who, due to emergency circumstances require that setting …will be deemed eligible…". Who decides or deems this? Who will pay? What will be the basis for anyone who is not LTC eligible? What is the definition of an emergency?

The determination of an emergency situation will be made by state staff, and the cost will be covered by Medicaid. In almost any conceivable situation the individual would be nursing home eligible. However, one example might be a spouse with Alzheimer's Disease who would be left alone and at significant risk when the other spouse is hospitalized. A definition of emergency situations was added to the final proposal.

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- What is the "Corrective Action Plan for Services"? Does this mean that services will be cut or reduced because a client has "overspent" Would this result in a freeze on services?

"Corrective Action Plan for Services" means that DA&D would be responsible for designing a plan to bring expenditures back in line with budget projections, should it appear that we were on a trajectory to overspend. This type of plan usually means taking actions such as freezing admission to non-entitled services until spending is brought under control.

- "SAMS & DAILCARE database in concert with EDS will track program finances and budget." Will SAMS 2000 really work and provide data needed?

The Department is confident the necessary financial and utilization monitoring will be in place.

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- What is "Enrollee Cast (sic) Sharing"? Is this different than the patient share? How will it work and what rules apply?

Cost sharing will apply to those individuals in the Moderate Needs group who are allowed to retain up to $10,000 in resources. For individuals in the Highest and High Need groups, the patient share will still exist. DA&D is working on the details of the cost sharing methodology.

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- Core Services Personal Care Services : How will DA&D determine that a spouse has sufficient skills to provide personal care services?

Such a determination will need to be made using an assessment (yet to be designed) that will gather the appropriate information need to make a determination. We will work with our community partners to design and test this assessment.

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- Respite Care…may be provided. What are the rules and guidelines for Respite care under the 1115? There is no description provided with any detail.

The Department anticipates that respite services will be delivered as they are today and will include both institutional and home-and community-based settings, as is the case today.

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- "Oversight, Monitoring, and Reporting" of Care Plans. This proposal acknowledges the dual role of HH agencies. Just how will DA&D propose to maintain a "Robust oversight." What are the specifics. This is a very important issue to clarify.

A Quality Assurance/Quality Improvement work group is meeting to determine the best way to measure outcomes and customer satisfaction. We will also be doing moe face-to-face interviews with participants and closely monitoring the amount and types of service delivered.

- DA&D will do a Quarterly Review for Q&A of 10% each Quarter. It would be important for DA&D to supply it's review criteria to AAAs and HH agencies to help them effectively monitor using the same standards.

The Department would be happy to share review criteria. Those criteria will be developed in conjunction with a work group that includes consumers, advocates and providers.

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- The Medicaid Waiver Teams Role: Not all Waiver teams currently review every active case each month, e.g., Rutland. If this is the standard for the 1115 Waiver additional funds will be needed to pay for case management and other hours needed for this task. It will consume considerably more Waiver Team time on a monthly basis.

The Department anticipates that many cases will be stable and not need to be reviewed each month. The intent is that the Team be aware of the cases and that case managers

bring issues to the team for discussion and input. Current Waiver Team practice will most likely be sufficient under the demonstration.